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A Practitioner's Complaint and Proposed Direction: Munchausen Syndrome by Proxy, Factitious Disorder by Proxy, and Fabricated and/or Induced Illness in Children

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Practitioners look to experts in a particular area to formulate and solidify diagnoses, dynamics, and other phenomena. Despite 30 years of literature, clarity and clinical direction are lacking in the case of Munchausen syndrome by proxy (MSBP), factitious disorder by proxy (FDBP), and fabricated and/or induced illness in children (FII). These diagnoses are rare, complex, and controversial, and their underlying dynamics and etiology are at best poorly understood by health professionals. Situations arise, nonetheless, requiring professionals to address these diagnoses under forensic scrutiny without solid scientific footing. This is the nature of the complaint addressed in this article, and the authors propose that these categories be reexamined using diagnostic conventions that already exist in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*; American Psychiatric Association, 2000) and applying the most recognized markers of FDBP for an acceptable individual and dynamic diagnostic description.

Keywords: diagnosis, parents, Munchausen syndrome by proxy, factitious disorder by proxy, fabricated and/or induced illness in children

As a practitioner, one hopes that the referral question provided by a client has clean and clear boundaries, is well researched in the literature, is discernable through recognized sources such as the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM–IV–TR*, American Psychiatric Association, 2000) and the *International Statistical Classification of Diseases* (10th rev., *ICD-10;* World Health Organization, 1992), and that there is agreement about it within the professional community. Here is our complaint as practitioners. The mental disorder diagnostic group including Munchausen syndrome by proxy (MSBP), factitious disorder by proxy (FDBP), and fabricated and/or induced illness in children (FII) lacks diagnostic precision, a substantive body of controlled research, and agreement within the health care community. For over 30 years (Meadow, 1977; Money & Werlwas, 1976), this set of diagnostic symptoms has remained elusive, unclear, and the point of considerable continued debate in professional literature and national policy. Yet, as will be illustrated in this article, the courts frequently make important decisions based on these diagnoses as if these matters were seemingly clear.

Most practitioners providing clinical services do not have ready access to the extensive stores of literature and research resources that one would need to take on such muddled subject matters as those presented by MSBP, FDBP, or FII. There are natural limitations on time and resources that are practical considerations, and for this reason this article will not be held out as a comprehensive review of the subject (see Rogers, 2004, and Sheridan, 2003, for such reviews). In fact, by one count listed in the literature, there were over 300 articles and four books as of the year 2000 (Korpershoek & Flisher, 2004, p. 1). While this voluminous literature exists, unfortunately, as Rogers (2004) and Sheridan (2003)

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described, this literature consists primarily of anecdotal case studies and little systematic controlled research. As a result, the practitioner has no solid set of resources to rely on to navigate this complex area of diagnosis, especially if called on to render an opinion in court.

Experienced practitioners are regularly called on to make challenging and complex diagnostic determinations. Many diagnostic conceptualizations are not simple matters involving a single diagnosis or dynamic description and, in fact, a good number frequently involve multiple diagnoses and several levels of dynamic considerations (Herman, 1992) that result in what one hopes is a well-grounded clinical conceptualization. A challenge, therefore, exists as to how a practitioner can reasonably explain to others outside of the behavioral health professions the complexities involved with the phenomena of MSBP, FDBP, and FII without coming across as confused, misinformed, or obfuscating. In attempting to explain these disorders, a practitioner may find that her or his credibility is strained by the lack of clear diagnostic precision, a substantive body of controlled research, and agreement within the mental health community. Professionals who continue to support these diagnoses in forensic testimony may do a grave disservice to the courts, children, parents, and the larger health profession if they do not acknowledge these shortcomings.

A Step Toward a Proposed Direction

Careful review of the literature on MSBP, FDBP, and FII reveals several different explanatory models with several dozen lists of indicators. By a conservative assessment of the literature, there are as many as two dozen lead diagnostic indicators and approximately the same number of dynamic indicators involved in making a determination of MSBP, FDBP, and FII. It is interesting therefore that *DSM–IV–TR* (American Psychiatric Association, 2000, p. 781) lists only four research criteria for FDBP (a diagnosis designated for further study). In *DSM–IV–TR,* FDBP is seemingly a diagnosis provided to an individual. Dynamics, on the other hand, are arguably addressed within the coding system of the *DSM–IV–TR* under what are called *V Codes*. The brief description of the function of V Codes states that there is "insufficient information to know whether or not a presenting problem is attributable to a mental disorder" (American Psychiatric Association, 2000, p. 5). As such, V Codes, and perhaps complex interpersonal dynamics, are not considered as important as real diagnoses. This perspective appears to be shared by third-party insurers, who commonly do not reimburse claims made for V Codes, for example, for marital discord and family deterioration. From their inception, MSBP, FDBP, and FII have all been described largely in dynamic terms, and their dynamic nature within the maltreatment literature has been a point of emphasis.

After our literature review, we develop a list of frequently reoccurring traits that describe the individual and interpersonal dynamic nature of MSBP and FDBP. These individual/dynamic symptoms are not only rare[1] and complex but controversial. Even our efforts to refine this list of characteristics and dynamic properties may still provoke some level of disagreement among professionals (Sanders & Bursch, 2002). For this reason, a discussion of what constitutes the individual and/or dynamic symptoms involved with MSBP and FDBP will follow, joined later by a discussion of FII. The import of acquiring a thorough understanding of these matters is best summarized in Artingstall's (1995) comments in *FBI Law Enforcement Bulletin*, "The more investigators know about MSBP, the better able they will be to identify perpetrators, clear innocent suspects, and most importantly, protect children" (p. 5).

Munchausen Syndrome and Factitious Disorder

In 1951 Asher initially used the term *Munchausen syndrome* to describe adults who fabricated illnesses to obtain medical attention, with no secondary gain except to adopt the role of illness through unnecessary medical procedures and treatments (Abdulhamid & Siegel, 2006). Munchausen syndrome was subsequently recognized in 1980 in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III;* American Psychiatric Association, 1980) under the heading of Factitious Disorder (p. 287); the diagnosis did not change much during the 20 years between the *DSM–III* and the *DSM–IV–TR* (American Psychiatric Association, 2000, p. 517). The additional term *by proxy*, therefore, extends the diagnosis beyond the *individual* to fabricate illness in another through whom this dynamic is acted out. The individual intentionally produces physical or psychological signs or symptoms in the child in order for the child to assume a sick role when incentives for this behavior are absent. While it is conceptually possible that a factitious disorder by proxy could involve another adult, the literature to date suggests that the proxy is a child, which becomes crucial when this diagnosis jumps the boundary from the consultation room to the courtroom.

Munchausen Syndrome and Factitious Disorder—by Proxy

There is substantial disagreement within the literature about MSBP and FDBP. One position is that these disorders do not constitute "a diagnosis in a traditional sense but an observational description with implications regarding cause" (Fisher & Mitchell, 1995, p. 532). Rogers's (2004) comprehensive article has provided one of the most thoughtful distillations of the complex matters that surround these diagnostic symptoms. While Meadow (1977) first described MSBP, Rogers (2004) cited Rosenberg's (1987) work to describe the four main characteristics of the syndrome:

> a. The child's illness simulated or produced by the parent/caretaker;
>
> b. Often persistent presentation for medical evaluation and treatment;
>
> c. The perpetrator's denial of any knowledge about the etiology of the illness; and
>
> d. The abatement of acute symptoms when separated from the perpetrator. (p. 226)

Despite Meadow's (1995) initial description of, and his continued remarks on, the MSBP diagnosis; it was Rogers's (2004) impression that FDBP was "more encompassing than MSBP in

[1] Estimates range from .0002 to .000003 (Alexander, Smith, & Stevenson, 1990; Sheerin, 2006; Huynh, 2006; Volz, 1995); but it is also often stated that legal authorities and providers simply do not know as it is believed that many cases go undetected. Stated another way, per Siegel and Fischer (2001, p. 33) citing Schreier (1997), "criteria suggests that 625 new cases per year can be expected in the United States."

allowing the classification of persons other than parents. However, it is more circumscribed in its delimitation of patients' putative motivation to the adoption of a 'sick role'" (p. 226). This creates a fine, but important, turn on the idea of FDBP; and parenthetically, Meadow (1995) had recommended expanding the notion of motivation from "adoption of a sick role" to include "attention-seeking behavior" (pp. 534–535).

As stated above, FDBP is included as a "Criteria Set Provided for Further Study" in the *DSM–IV–TR* (American Psychiatric Association, 2000, p. 783). The criteria are as follows:

> a. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care.
>
> b. The motivation for the perpetrator's behavior is to assume the sick role by proxy.
>
> c. External incentives for the behavior (such as economic gain) are absent.
>
> d. The behavior is not better accounted for by another mental disorder. (American Psychiatric Association, 2000, p. 783).

Other literature also has indicated that the alleged MSBP/FDBP parent/caretaker engages in a "relationship" with medical providers in which attention-seeking behavior may be more evident than the adoption of a "sick role" per se (Donald & Jureidini, 1996; Schreier & Libow, 1993). This suggests that the *DSM–IV–TR* (American Psychiatric Association, 2000) research criteria may be too narrow in FDBP.

Rogers (2004) clearly elucidated substantial fundamental flaws involved with these individual and/or dynamic diagnoses. In a classic sense, diagnoses are made on the basis of fundamental rubrics such as criteria for *inclusion*, *exclusion*, and *outcomes*. Citing Syndeham via Murphy, Woodruff, Herjanic, and Fischer (1974) Rogers clarified that fundamentally "every disorder must have inclusion, exclusion, and outcome criteria" (p. 227). He further illustrated the challenges with the diagnosis of FDBP:

> The proposed inclusion criteria do not delineate symptoms for the person with FDBP, but rather for the effects of apparent symptoms on others and the putative motivation for producing these effects. In addition, the sole exclusion criterion ("not better accounted by another mental disorder"; American Psychiatric Association, 1994, p. 727) is simply too vague to be useful. Finally, studies of outcome criteria (e.g., Bools, Neale, & Meadow, 1994; Libow, 1995) tend to focus on the child victims rather than the FDBP parents. (p. 227)

Rogers (2004) also pointed out that, when larger issues such as motivation are considered, incentives extend beyond a circumscribed sick role. Rogers called for consideration of the possible diagnosis of malingering by proxy. With this diagnosis, the individual would be conceptualized as not only consciously feigning signs and symptoms but as motivated to do so to obtain an external incentive.

An Individual Diagnosis, a Dynamic Diagnosis, or Both?

In addition, there is another point of controversy regarding these individual and/or dynamic diagnostic terms. Since at least its initial description, MSBP has been considered a complex, fourfold dynamic rather than a diagnosis per se (Meadow, 1977; Money & Werlwas, 1976; Robins & Sesan, 1991; Rosenberg, 1987). Further, Rand and Feldman (1999) coherently presented this issue, considering misdiagnoses of the "disorder" and questioning the premise of whether it is a diagnosis. Invoking Feldman and Ford (1994) as well as Meadow (1995), they stated, "Psychiatric diagnoses should have extremely limited use in this type of crime . . . . . The term [should] be reserved for the complex abuse that results when an adult perpetrator actively deceives medical providers in order to gain emotional gratification" (p. 95). Therefore, according to Rand and Feldman, this description distills to what one might describe as a dynamic that could be seen as a "complex maltreatment interaction dynamic between the parent/caretaker, child and medical staff" (p. 100).

Obviously, an interpersonal dynamic such as this has complex elements, as addressed by the American Professional Society on the Abuse of Children (APSAC) Task Force on MSBP (Ayoub et al., 2002; Ayoub, Schreier, & Alexander, 2002; Schreier & Ayoub, 2002). The task force suggested that MSBP be abandoned as the primary descriptive term (Schreier & Ayoub, 2002), and instead clinicians were encouraged to take a stepwise approach in which child abuse is identified first. The task force labeled this dynamic as *pediatric condition falsification* (PCF), in which two elements of the dynamic are present: (a) abuse has occurred to the victim, and (b) a parent has perpetrated the abuse. The second step in identifying this dynamic assessed for FDBP via the criteria from *DSM–IV–TR* (American Psychiatric Association, 2000). As Pankratz (2006) pointed out, this is no easy matter, either, as a diagnosis of PCF is based on the notion that the parent/caregiver has "falsified" the medical record. Pankratz stated:

> During careful interviews, ordinary mothers provided information that was not consistent with the medical records of their children. The findings in this study suggested that mothers say what they believe at the time.
>
> The base rate for misinformation in the pediatric setting may be high, but this does not necessarily reflect evil intentions. Falsification can arise from simple mistakes or complex psychodynamic drives; clinicians must evaluate and minimize these risks. Yet, attorneys comb the massive records of chronically disabled children looking for the smallest discrepancies, which are then paraded before the court as falsifications. This has a powerful effect on the whole process because anything that the mother says thereafter in her own defense can be dismissed as a part of her pattern of lies.
>
> Many articles on MSBP recommend comprehensive evaluations, but the diagnostic labels of pediatric condition falsification and MSBP often divert the assessment process and management planning into a contentious legal battle. The purpose of a multidisciplinary team, of course, is to assess different domains of function and, one hopes, to avoid viewing the patient through a diagnostic peephole.
>
> Once a problem is perceived as MSBP or pediatric condition falsification, the focus easily turns to simplistic blaming instead of assisting the mother in the management of her child. Most often, the planning sessions of child protective services result in the assignment of burdensome tasks for the parents to earn back their child even when there has not been evidence of harm. (pp. 92–93)

Though to an extent incomplete, the findings of Rosenberg (1987) and the APSAC Task Force on MSBP (Ayoub et al., 2002) do give us a possibly identifiable maltreatment dynamic. Their schematic for understanding this proposed maltreatment dynamic (one endorsed by a sizable number of clinicians) still has noteworthy

problems; these are with both the first arm, which describes PCF (Pankratz, 2006), and the second arm on the diagnosis of FDBP—which, as Rogers (2004) has stated, is problematic at best. These considerations do not yield an answer to the question of whether MSBP or FDBP is an individual or dynamic diagnosis. Instead, this discussion suggests that we currently have elements of both, which the well-qualified task force attempted to tease apart.

Misdiagnoses, Solutions, and Other Issues

With this level of individual and interpersonal dynamic diagnostic confusion, determining whether to diagnose or describe MSBP and FDBP is at best problematic. Rand and Feldman (1999), Hyman, Bursch, Beck, DiLorenzo, and Zeltzer (2002), and Schreier (2000) have all reported that a number of parents have been misdiagnosed because of subjectivity and errors in understanding the nature of the diagnosis/dynamic. Citing Pankratz's (1998, 1999) key criteria for diagnosing MSBP, Rand and Feldman articulated some of the steps that were absent in these cases: "Although the mothers had psychological problems, neither was attempting to assume the sick role by proxy, and neither had engaged in active deception" (p. 96). As Korpershoek and Flisher (2004) stated, "A misdiagnosis of MSP could have hefty implications for the alleged perpetrator" (p. 4). This diagnostic imprecision has contributed to recent literature that has not only been critical of this set of individual/dynamic diagnoses but has offered steps toward clarifying matters, with Korpershoek and Flisher's further caveat, "whilst not recognizing the syndrome could have serious implications for the child" (p. 4).

However, it is clear that these individual/dynamics diagnoses are at the least rather challenging because debate led to a 2006 publication by the *Journal of the American Academy of Law* titled "Persistent Problems with the Munchausen Syndrome By Proxy Label" (Pankratz, 2006). Additionally, Artingstall (1995), cautioned that 60% of mothers accused of MSBP and FDBP attempted suicide:[2] "Despite seemingly strong circumstantial evidence present in some cases of apparent MSBP abuse, law enforcement officers must make every effort to refrain from making false allegations. Accusations based on insufficient investigation and absent forensic analysis can have disastrous consequences" (pp. 8–9).

Rogers (2004) strongly suggested that "a research priority is the establishment of symptoms and other characteristics that reliably differentiate FDBP from other disorders" (p. 229). He suggested three categories for inclusion: FDBP criteria, proxy–victim characteristics, and relationship variables (parent–victim and parent–physician).

Scientific Certainty: *Daubert v. Merrell Dow Pharmaceuticals* (1993)

The standards developed for the level of scientific certainty acceptable in legal proceedings require consideration here. We conducted a simple, but telling, literature review. The criteria for the literature search at minimum included the names or phrases *Daubert* and *scientific certainty*, and then also *factitious disorder by proxy* and *Munchausen syndrome by proxy*. When the search was conducted this way, PsycNET, the main search engine available for psychological publications, returned no results. The majority of professional references that were found by other means expressed the sentiment that, as an individual and/or dynamic diagnosis, FDBP and MSBP are difficult to define at best. At worst, as Lucire (2000) stated, "Experienced practitioners agree that this phenomenon has reached epidemic proportions and has all the characteristics of mass hysteria, now termed *moral panic*" (p. 45).

In fact, the categories of MSBP and FDBP are considered so unreliable in the United Kingdom (Adshead, 2005; Pagnell, 2006[3]) that there is active discussion about abandoning them altogether in favor of still another term, *fabricated and/or induced illness* in children (FII; see Royal College of Psychiatrists, 2006). FII has been actively debated for the past several years. The Royal College of Psychiatrists further stated, "FII had come just at the time when there had been a sustained attack on the position of professionals—not just in Britain—where the idea of professionals as a source of expertise had been discredited" (¶7). Yet, despite the critical opinions in the literature, represented best in Pagnell (2006), Pankratz (2006), and Rogers (2004), as well as in public opinion calling for change, courts frequently have accepted these diagnoses through the *Daubert* standard or the Federal Rules of Evidence (i.e., Federal Rule 702). As described by *State of Delaware v. McMullen* (2006):

> At its core, *Daubert* dictates that Rule 702 is the governing standard for the admissibility of scientific evidence by specifying that "*if scientific*, technical, or other specialized knowledge *will assist the trier of fact* to understand the evidence or to determine a fact in issue," then the expert "may testify thereto." (p. 28).

Also, the *People of the State of Illinois v. B.T.* (2005) decision illustrated these considerations further:

> The crux of respondent's argument is that factitious disorder by proxy has not achieved general acceptance because it is not a formal diagnosis under the DSM IV standards (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, at 781–783 (4th rev. ed. 2000) . . . .
>
> We note that all the experts, including respondent's, testified consistently at trial that factitious disorder by proxy was a recognized research criteria diagnosis by the American Psychiatric Association instead of a formal diagnosis because more research was needed before it could appear in the body—rather than appendix—of the diagnostic manual and researchers had not yet developed a specific profile regarding what symptoms indicated the disorder. We also note that other jurisdictions have found evidence regarding factitious disorder by proxy, earlier known as MSBP, admissible under either *Frye*, *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 125 L. Ed. 2d 469, 113 S. Ct. 2786 (1993), or state rules of evidence. See *People v. Phillips*, 122 Cal. App. 3d 69, 86-87, 175 Cal. Rptr. 703, 713-14 (1981) (testimony regarding objectively verifiable symptoms leading to a diagnosis of MSBP was admissible as garden variety

[2] It is vague in her article whether she is referring to a demographic preceding the accusation, or if this occurred after being accused of the crime—it seems the latter.

[3] MSBP/FII has also been the subject of contentious debate in the U.K. Parliament on several occasions and, in a parliamentary debate on October 17, 2004, Earl Frederick Howe said of MSBP/FII, "[It is] one of the most ill-founded and pernicious theories to have gained currency in child care and social services over the past ten to fifteen years" (Pagnell, 2006, ¶16).

expert testimony, was not a new scientific development, and it made no difference that the syndrome might be an unrecognized illness or not listed in the diagnostic manual of mental disorders); *State v. Hocevar*, 300 Mont. 167, 184-85, 7 P. 3d 329, 341-42 (2000) (expert testimony regarding MSBP was not novel to the field of pediatrics or law and was admissible under the rules of evidence). (Lines 337–360).

Given the tendency of courts to admit evidence of MSBP, FDBP, and FII, we offer the following list of characteristics for comparison, duly noting the basic research imperative that correlation does not equal causation.

A List of Characteristics Associated with Factitious Disorder by Proxy

A list of FDBP characteristics that appear frequently in the literature has been provided in Table 1 for direct comparison between an alleged perpetrator diagnosis (FDBP) and a child maltreatment dynamic. We relied heavily on the work of Rogers (2004) and Artingstall (1995), the *DSM–IV–TR*'s (American Psychiatric Association, 2000) research criteria, and Rosenberg's (1987) description of MSBP in formulating this list of FDBP characteristics, as well as the criteria found in Korpershoek and Flisher (2004); Rand and Feldman (1999); Siegel and Fischer (2001), and other literature. Other points are cited as well that are not so closely tied to the work above; some appeared only in certain articles, and for others there is some level of disagreement surrounding the question as an indicator of FDBP.

Although, to this point, MSBP, FDBP, PCF, and FII have all been given relatively equal footing, the latest literature makes it clear that there is a trend toward consolidation around the term *FDBP*. This is presumably due to the *DSM–IV–TR*'s (American Psychiatric Association, 2000) research criteria, with the possible exception of the current trend in the United Kingdom. Efforts here will focus on this term, which has elements of both an individual diagnosis and a dynamic diagnosis.

Table 1 reflects a set of comparisons based on our opinion that FDBP is both an individual diagnosis and an interpersonal dy-

Table 1
Factitious Disorder by Proxy (FDBP) Diagnosis and FDBP-Child Maltreatment Dynamic

Factitious Disorder by Proxy Diagnosis
1. History of behavioral health treatment (I, E; Artingstall, 1995; Schreier, 1997, 2000).
2. Diagnosed with, or suspected of having, symptoms and traits of factitious disorder (I, E; Artingstall, 1995; Bools, Neale, & Meadow, 1994).
3. Diagnosed with, or suspected of having, traits of a personality disorder (I, E).
4. Primary caretaker of the child (I, E).
5. The individual is a female (I, E; Sheridan, 2003; Siegel & Fischer, 2001).[a]
6. Background or training in medicine (I, E; Artingstall, 1995; Chiczewski & Kelly, 2003; Korpershoek & Flisher, 2004; Siegel & Fischer, 2001).
7. Similar medical history to that of the child presented for evaluation (I, E; Bools, Neale, & Meadow, 1994).
8. Views her- or himself as "unique" in a characterological sense (I, E).
9. A history of sudden infant death syndrome (SIDS) or similar unusual death within the family close to the individual (I, E, O).
10. Psychological assessment instruments indicate a level of defensiveness on validity scales (I, E, O; see Rogers, 2004, for a detailed discussion of this matter, p. 232).
FDBP-Child Maltreatment Dynamic
1. A pattern of multiple visits to medical providers/hospitals in which there has been a growing suspicion of some form of abuse—mean time frame 14 months (I, E, O; Sanders & Bursch, 2002, suggest a chronology and table of events in most cases[b]).
2. There has been no established medical condition that would explain persistent symptoms (I, E, O).
3. The suspected victim's symptoms worsen over time (I, E, O).
4. The suspected victim is a child between the ages of infancy and 8 years (I, E, O).[c]
5. The suspected perpetrator is the suspected victim's primary caretaker, and in the vast majority of cases (75–95%) is the mother (I, E; Sheridan, 2003; Siegel & Fischer, 2001).[d]
6. Confirmed medical findings that the suspected victim has been abused (I, E, O).[e]
7. Abuse has taken the form of drugging, fever induction, poisoning, seizure induction and suffocation (apnea, SIDS, etc.; I, E, O).
8. *Medical Provider Subdynamic*— suggests suspected perpetrator has established a relationship dynamic with medical staff wherein: (a) The individual lacks appropriate boundaries (I, E; Siegel & Fischer, 2001), (b) Is demanding (I, E), (c) Seeks attention (I, E), (d) "Thrives" in the medical hospital or office environment (I, E), (e) And is gratified by interactions with medical staff (I, E).
9. *Caretaker–Child Subdynamic*, suggests that the caretaker has established a relationship dynamic with the child wherein: (a) The individual is overinvolved with the child (I, E), (b) The individual is unwilling to leave the child's presence (I, E), (c) And the child's symptoms worsen in the presence of the suspected individual (I, E, O).
10. The suspected perpetrator encourages and welcomes additional tests, etc. that will maintain or extend time spent interacting with medical providers, regardless of the effects on the suspected victim (I, E, O; Siegel & Fischer, 2001).

Note. I = criteria for inclusion; E = criteria for exclusion; O = criteria for outcome.
[a] While it is far less prevalent, men and close relatives have been identified as perpetrators. [b] Their emphasis was on establishing, in short, what has come to be known as pediatric condition falsification (PCF) via a thorough records review. They stated: "The cornerstone of an MBP evaluation is the assessment of the veracity of claims made by the suspected caregiver" (p. 114). [c] Some authors have put this age up to 16. [d] Though it is far less prevalent, men and close relatives have been identified as perpetrators. [e] This element and 7 are where the idea of pediatric condition falsification (PCF) would best apply.

namic diagnosis. We propose that this lack of integration is why the literature on the matter is so confounded. As such we are attempting to capture both a diagnosis that exists for one individual, or perhaps two (*folie à deux*), and to describe a larger complex dynamic between the alleged perpetrator, the alleged victim, and the medicolegal system. The hazards of addressing larger complex dynamics alone have long been described throughout the bodies of literature on abuse and neglect, family systems, groups, and industrial–organizational matters. Our concerns about the loss of objectivity lie at the center of the problem of false positives, which can have chilling ramifications.

Parceling out the current research criteria for FDBP (American Psychiatric Association, 2000, p. 783), we label the criteria according to whether they are an element of an individual diagnosis or of a dynamic diagnosis, remaining mindful of Rogers's (2004) comments on inclusion, exclusion, and outcome criteria (p. 227). With Rogers's proposals and the *DSM–IV–TR* criteria in mind, we propose that the following descriptors be considered as an initial sketch that introduces Table 1.

> a. Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care (*DYNAMIC*).[4]
>
> b. The motivation for the perpetrator's behavior is to assume the sick role by proxy (*DIAGNOSIS/DYNAMIC*).
>
> c. External incentives for the behavior (such as economic gain) are absent (*DIAGNOSIS/DYNAMIC*).
>
> d. The behavior is not better accounted for by another mental disorder (*DIAGNOSIS*).

As the reader is able to see, in our opinion, three out of four research criteria describe an interpersonal dynamic rather than an individual mental disorder diagnosis, and only one of the criteria cleanly provides a traditional diagnostic basis for FDBP.

Bearing these concerns in mind, we hope that Table 1 will supply characteristics that describe both the individual and dynamic diagnostic features of FDBP in order to create some level of objective points of comparison. This list is by no means exhaustive nor the product of controlled research; rather, it comes from the suggestions of experts in the field and recurring characteristics seen within the literature. It is meant to serve as a practical starting point for examination of FDBP following 30 years of literature on the topic.

Child maltreatment is the most frequent social/interpersonal system dynamic associated with FDBP, "in which an adult falsifies physical and/or psychological signs and/or symptoms in a victim causing that victim to be regarded as ill or impaired" (Sanders & Bursch, 2002, p. 112). In short, there is what one may call a *factitious disorder by proxy child maltreatment dynamic,* which is described in Table 1. Other cogent subdynamics referenced in the literature have also been included. Each comparison in the list has markers in parentheses beside it to indicate that it meets Rogers's (2004)[5] criteria of inclusion (I), exclusion (E), and outcome (O).

The reader is encouraged to think of these lists as comparable attributes in terms of percentages of agreement (e.g., 1 out of 10 being 10%). While no magical cutoff point is proposed, the reader is encouraged to consider these percentages qualitatively within the larger context of an overall assessment, as well as what may tip the scales (DeMatteo & Edens, 2006, pp. 231–233). These comparisons are based on probabilities clustered together that result in a set of individual and dynamic diagnostic profiles. Not all FDBP cases entail the same diagnostic features in the alleged perpetrator or alleged victim or with the same maltreatment dynamic properties. Siegel and Fischer (2001) have offered this useful caution, "Some FDP perpetrators are uneducated, dramatic, emotionally labile, hostile, and obviously dishonest (Parnell, 1998), whereas others are out to harass physicians, hoping to profit from malpractice suits (Rosenberg, 1995) or benefit from governmental services and programs (Artingstall, 1995)" (p. 36).

We offer 20 points of consideration about what comprises FDBP. This list (Table 1) reflects both the complexity of the phenomenon and provides a set of concrete reference points to incorporate individual and dynamic comparisons for a proposed revision of the FDBP diagnosis that is more holistic and inclusive. We suggest that both the individual traits and the maltreatment dynamic be present before an FDBP diagnosis is made.

Implications

The scientist–practitioner understands that correlation does not equal causation and, as scientists addressing the multifaceted elements, we understand that assessing FDBP is not as simple as cataloging individual and dynamic diagnostic variables (Palermo & Kocisc, 2005; Sanders & Bursch, 2002). As practitioners, we also know that matters are more complex than they seem (Shah, 1989). There are limits to consider as well: "Behavioral science and research does not offer certainty. (Neither does natural science!) It does not even offer relative certainty. All it offers is probabilistic knowledge: If A is done, then B will probably occur" (Kerlinger, 1979, p. 28). Lately, however, there have been more powerful probabilistic models offered in behavioral science (Wollert, 2006), and there is a growing recognition of the subtlety and power of statistical science and the potential weight that these determinations have on our clients (Flynn, 2006). In our experience, what practitioners seek from experts are clear, usable guidelines for addressing behavioral phenomena that reflect the real world.

Possibly, limitations in grasping the complexity of FDBP may lie in the kind of provider called upon to address FDBP (Artingstall, 1995), and it may be important to emphasize the need for specialized training in order to adequately discern the diagnosis and dynamic properties of FDBP. Further, the use of a multidisciplinary team to assess FDBP is repeatedly recommended in the literature, and the family therapy literature contains ample references to a clinician's limitations in maintaining objectivity, given the power of family dynamics (e.g., Palazzolli-Selvini, Boscolo, Cecchin, & Prata, 1978).

Bearing the complexities of FDBP in mind, we propose a direction that may provide a way to simplify and focus the assessment of FDBP. In utilizing the diagnostic and dynamic properties of FDBP above, we offer a ready heuristic that exists within the *DSM–IV–TR*. For example, a child is traumatized and suffers from

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[4] These notations are ours for purposes of clarification and are set off in parentheses and italics.

[5] "A research priority is the establishment of symptoms and other characteristics that reliably differentiate FDBP from other disorders" (p. 229).

posttraumatic stress disorder (PTSD) after he or she has been physically abused. Both issues are commonly coded, that is, PTSD and Physical Abuse of Child. PTSD provides the individual diagnosis, while Physical Abuse of Child provides the etiology and social context of the diagnosis, or what we refer to as its *dynamic* aspect when it refers to the victim (American Psychiatric Association, 2000, p. 738). When the Physical Abuse of Child refers to the alleged perpetrator, then a V Code is also given and again implies a *dynamic* aspect, though the *DSM–IV–TR* does not state it as such. We suggest that experts consider the matter of FDBP as both an individual diagnosis and as a dynamic diagnosis, with coding systems that integrate both aspects to capture the individual, interpersonal, social, and legal complexity of the phenomenon.

Provided these considerations, tying down the phenomenon of FDBP to provide only one diagnosis not only creates real difficulties descriptively but ignores the cultural challenge that involves interpersonal dynamic diagnoses. These diagnoses have not been well recognized in the existing *DSM* coding system. We submit that perhaps MSBP, FDBP, and FII may collectively be a forerunner of the more sophisticated practice of wedding individual diagnoses and group, social, family, and legal dynamics together into an integrated, coded conceptualization.

Expanding these considerations further, in examining the child protection rules and statutes within states we have certainly considered that these legal standards may apply to others besides children. The protective laws of many states also include those who have developmental and intellectual disabilities, the aging, and other vulnerable adults. While the literature repeatedly suggests that there are many more cases of FDBP that go undetected, this may especially hold true for those other than children. Those who are vulnerable to the dynamic of maltreatment in FDBP may be well beyond the current view of this phenomenon as a parent–child disorder and beyond the machinations of the individual who fits the current diagnostic criteria for the disorder.

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